

Virginia START Quarterly Consult Summary 10/12-12/12

Following is a summary of progress in the development and implementation of statewide START services in the state of Virginia from October 1, 2012 through December 31, 2012.

Implementation of VASTART Services Summary

Following is an analysis of cumulative data reported in START Information Reporting System (SIRS) until the end of this reporting period (12/31/12).

Background

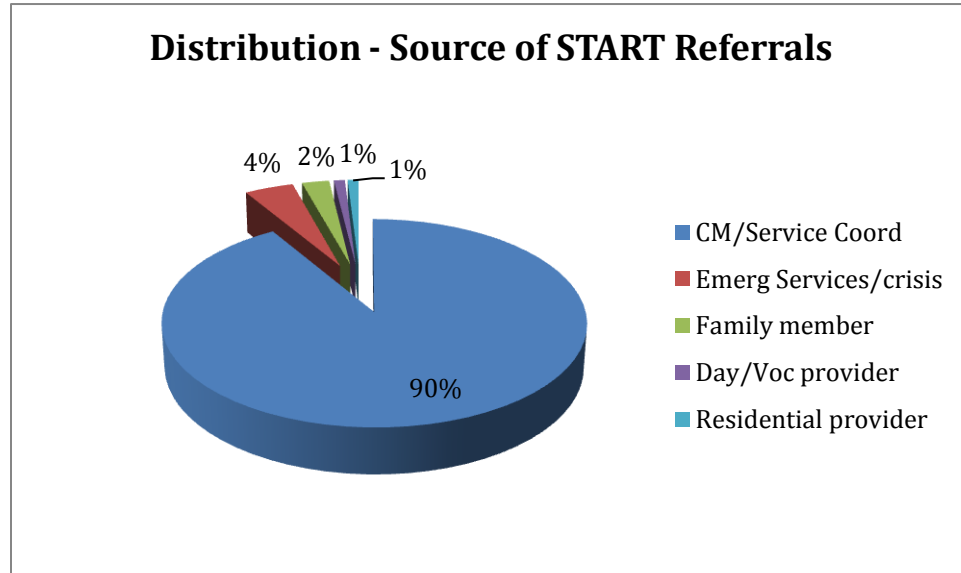
Since Regions 1 and 2 were not licensed until late in the quarter they have provided limited services. In addition, Respite services were limited to Region 3. Therefore, this report provides limited data for services provided statewide, as other services are in development.

As of 12/31/12, 233 individuals have been entered into the SIRS data system and are receiving services through VA START. Compared to the first quarter report, this is an increase of 47% in the number of individuals served and documented in SIRS.

Client Data

Following is data from referrals during the reporting period. There were a total of 233 clients entered into the SIRS system between July 1 and December 31, 2012. The total number summarized in this report is 233: Region 2 = 32, Region 3 = 86, Region 4 = 67, and Region 5 = 48. It is not surprising that Region 3 has the most service recipients since it is the only region that is fully operational. We do not have any data reported from Region 1. However, this will be resolved by the next reporting period.

Referrals Sources



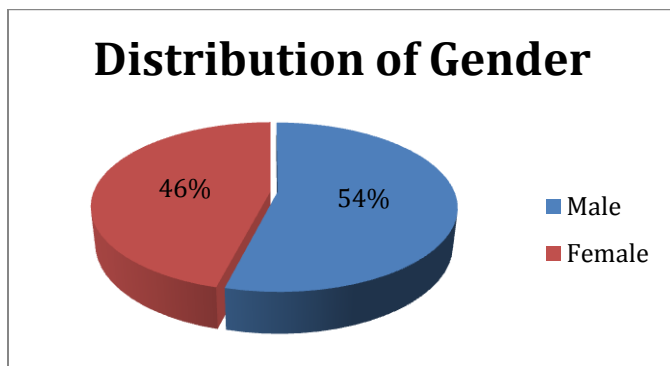
This table portrays the reported source of referrals in the SIRS. The data indicate that the vast majority of referrals came from case managers/care coordinators (90%).

Emergency/crisis services referred 4%, family members referred 2%, and residential and day program providers each referred 1%.

Population information

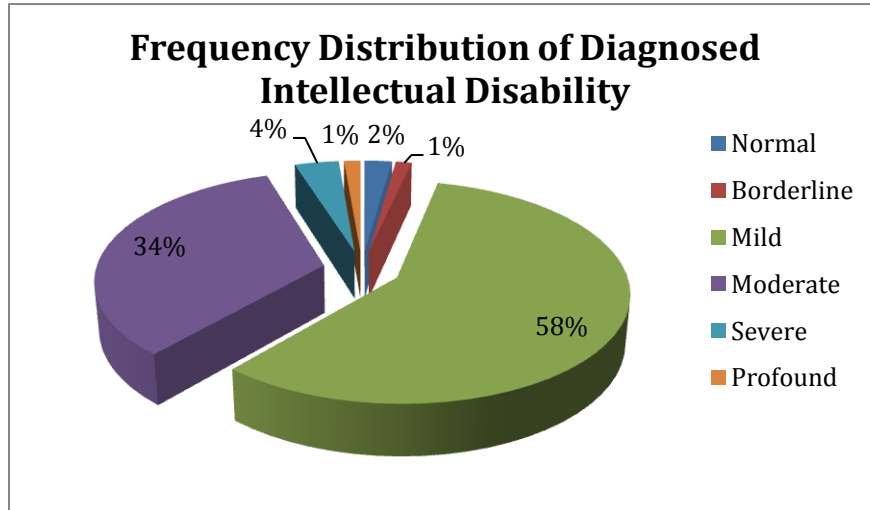
The following provides key information about the population served by VASTART.

Gender



54% of all referrals were male, while 46% of referrals reported were female.

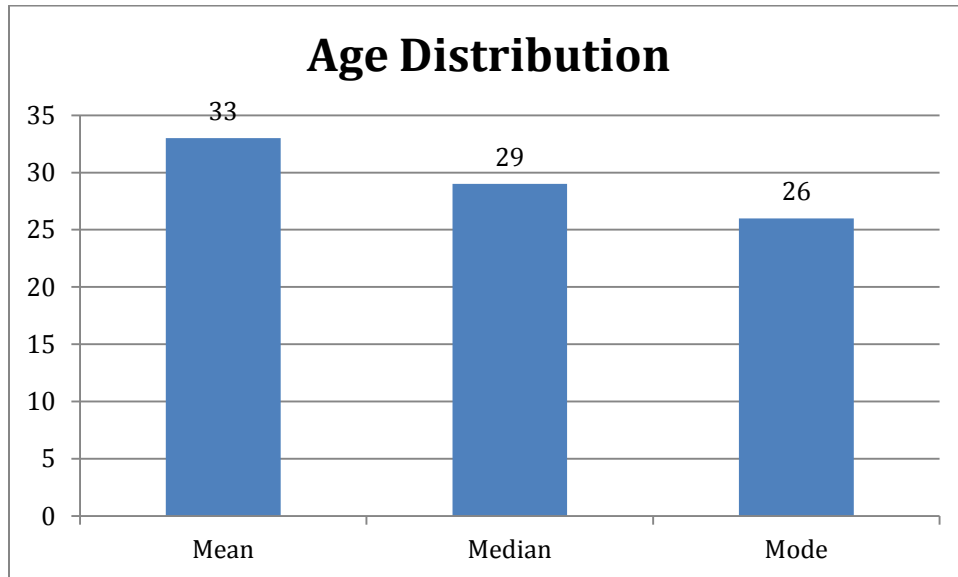
Level of Intellectual Disability



According to the data reported to date, as expected, the predominant number of persons referred has mild intellectual disability (58%), followed by moderate ID (34%), severe ID (4%) and profound ID (1%). In addition, 3% of individuals referred do not have a diagnosed intellectual disability. As would be expected, the VA START ID population is more disabled than the general population of people with ID where 80% or greater would be expected to have Mild ID, and about 25% would be expected to have Moderate ID. This indicates that the population of individuals served by VA START is more vulnerable than the general population of individuals with Intellectual Disabilities.

The data indicate that 2% of the population does not have a diagnosed ID and may reflect referrals to date of individuals with ASD who do not also have ID. This number will be closely monitored to insure that people with ASD and Mental Health needs who could benefit from START are accessing the services.

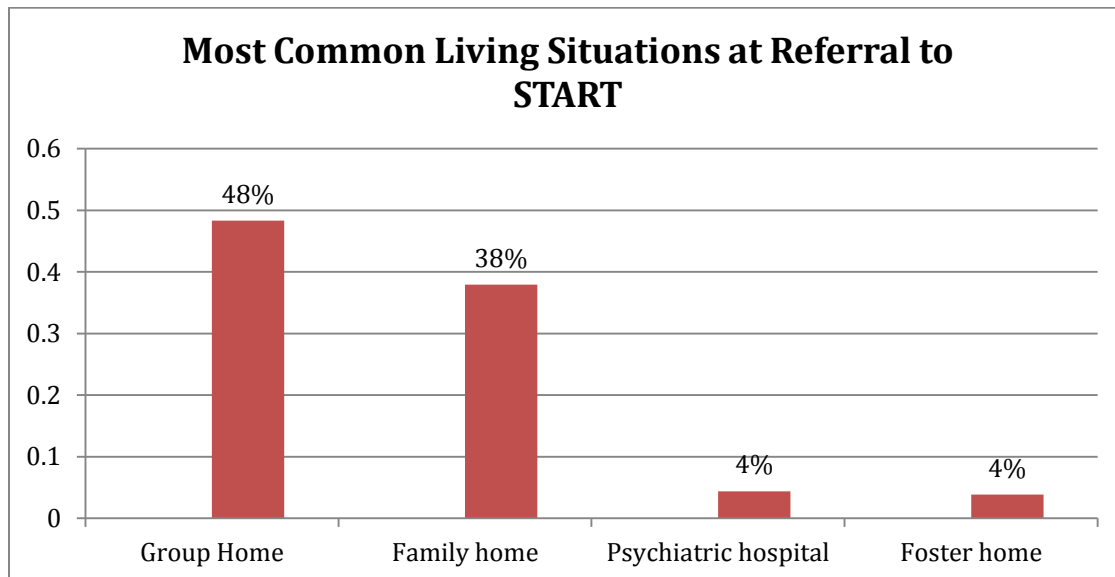
Age



The age range of referrals was from 18-70. The mean or average age is 33; the median age was 29; and the mode, or most common age reported, was 26. This indicates that a young adult population is the most prevalent referral so far, a finding found in other programs throughout the U.S.

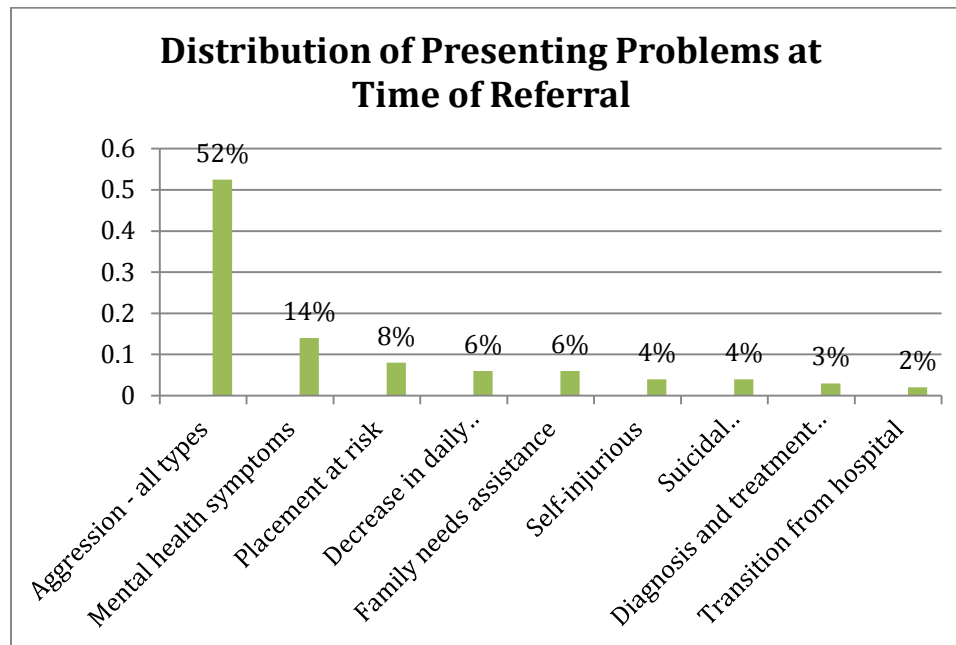
Residential Setting at Time of Referral

The table below presents a frequency distribution of residence at the time of referral.



As expected, nearly half or 48% of individuals referred resided in group homes at the time of referral. The distribution of referrals also indicates that 38% of all referrals are of people who lived with their families. In addition 4% lived with foster families. This means that 42% of referrals reside in family settings, an excellent outcome and on target for START programs. Given the rapid rate in which families are being referred, Virginia may exceed other states in support provided to families. 4% of the population was referred from psychiatric hospitals. This will allow greater partnership between START teams and mental health providers.

Presenting Problems at Time of Referral



The average number of problems reported per referral was approximately 3. The majority of presenting problems at the time of referral were as expected due to some form of aggression (52%), followed by general mental health symptoms (14%). Other mental health symptoms reported included suicidal ideation (4%), self-injurious behavior (4%), and decreased ability to function (6%).

Presenting problems also included some service related problems. A number of individuals were identified as at-risk of losing placement (8%); need for family assistance (6%), the need for diagnostic and treatment assistance (3%), and transition from hospital (2%).

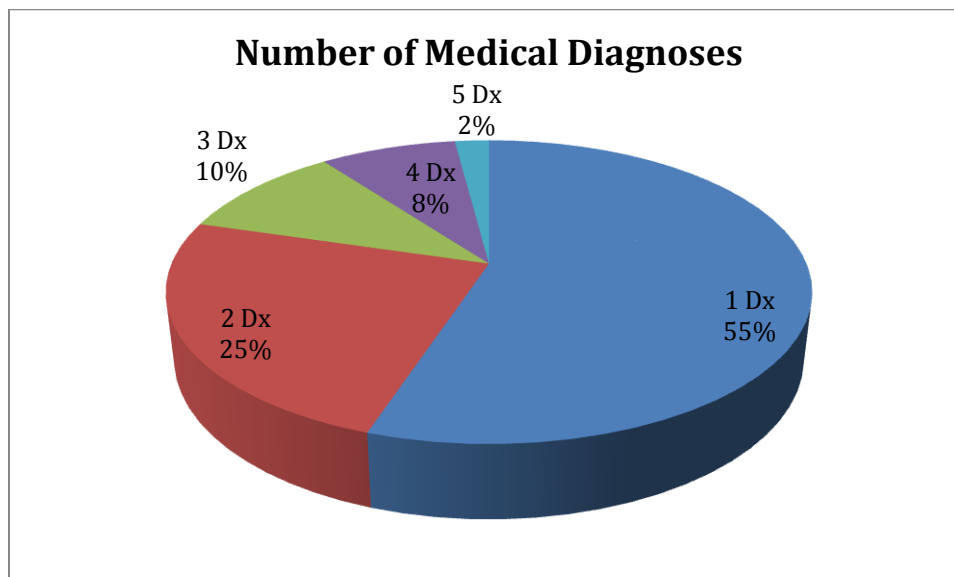
Medical Diagnoses

In other START programs, the population is most often a medically fragile one. In Virginia, medical conditions may be under-reported to date. Medical conditions were only reported on 49 of the 233 clients (21%) entered into the SIRS system and of those individuals, 55% reported only one medical condition. The frequency distribution of medical diagnoses is

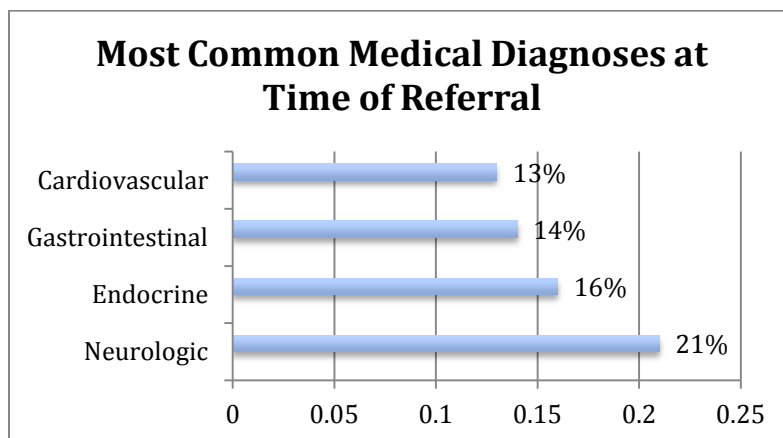
unusual when compared with cohorts from other START programs in the U.S. where, on average, three medical conditions are being treated per client.

Medical Diagnoses

Individuals	49
Number of Med Dx	91
Average per person	1.9
Range	1 to 5
Mode	1

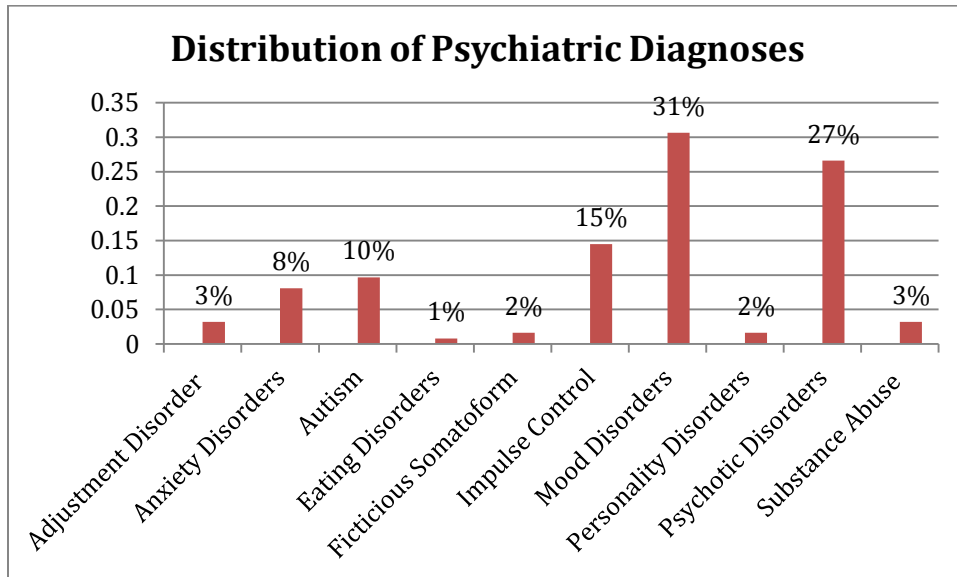


The table that follows indicates the type of medical diagnoses most commonly found for those diagnosed with medical conditions. As expected, the majority had seizure disorders (21%), followed by Endocrine Disorders (16%), Gastrointestinal disorders (14%), and Cardiovascular disorders (13%).



Mental Health Diagnoses

The following chart details mental health diagnoses at the time of referral. The data continues to show a trend that in Virginia, of the many whom received mental health services (including the majority who receive medications), only 53% (124 of 233) reported DSM IV-R diagnoses at the time of referral. This trend is a concern that indicates more training and technical support to MH providers is needed.

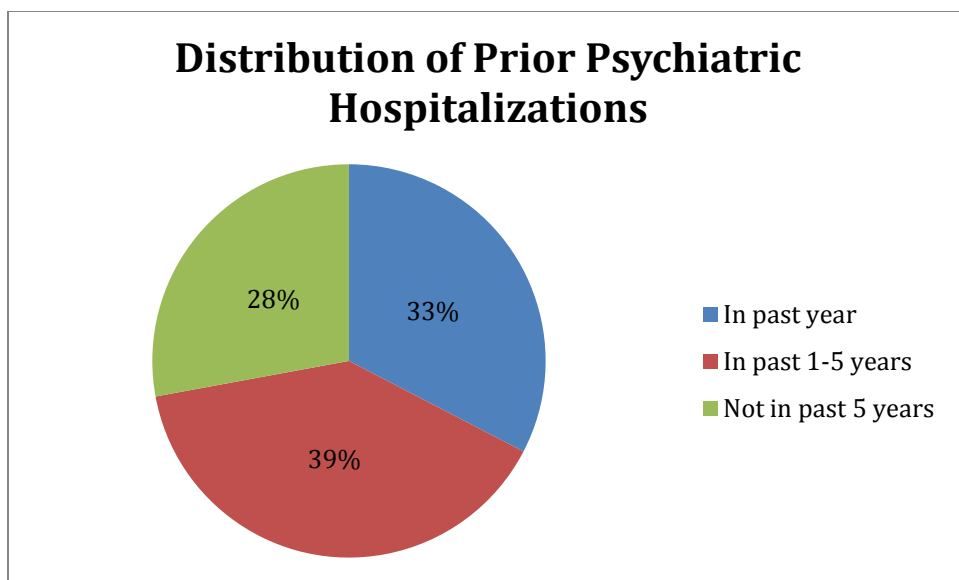


A significant number of individuals (44%) had no reported mental health diagnoses in the SIRS as of December 31, 2012. The data is not consistent with other findings nationally where there is a prevalence of anxiety disorders, depression, and PTSD.

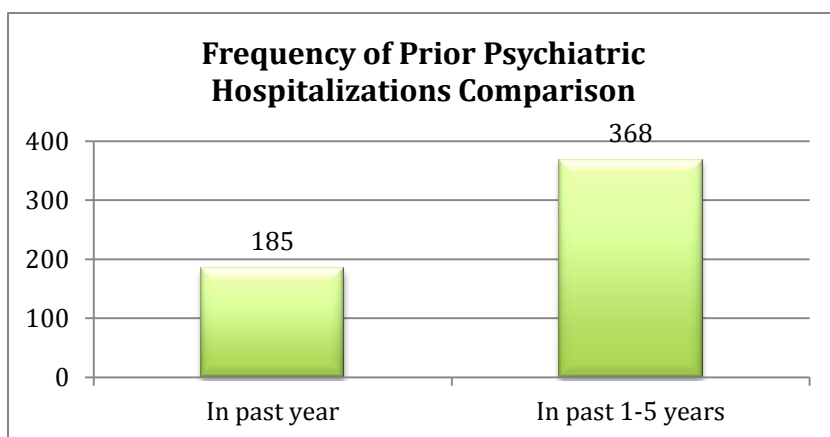
The mental health diagnosis data may indicate the need for more education of treaters and greater expertise in serving individuals with I/DD who have mental health needs. This is a goal of VA START and will be monitored closely over time.

Psychiatric Hospitalizations

Despite of the lower than anticipated number of mental health diagnoses recorded in SIRS for the individuals referred to START to date, a high number have had psychiatric hospitalizations according to the data reported.



As detailed above, according to SIRS data 72% of referrals (n=168) to date had a previous history of psychiatric hospitalizations. Since this is the target population for referrals, this is not an unexpected finding. A goal of the VA START program is to enhance community capacity overall to reduce the need for hospitalization whenever possible. We will pay close attention to recidivism rates and length of stay as measures of effective access to inpatient care. Again, the mental health services delivered to the population to date indicate more information, training and communication between START teams and MH providers will be needed as the teams move forward in service implementation.



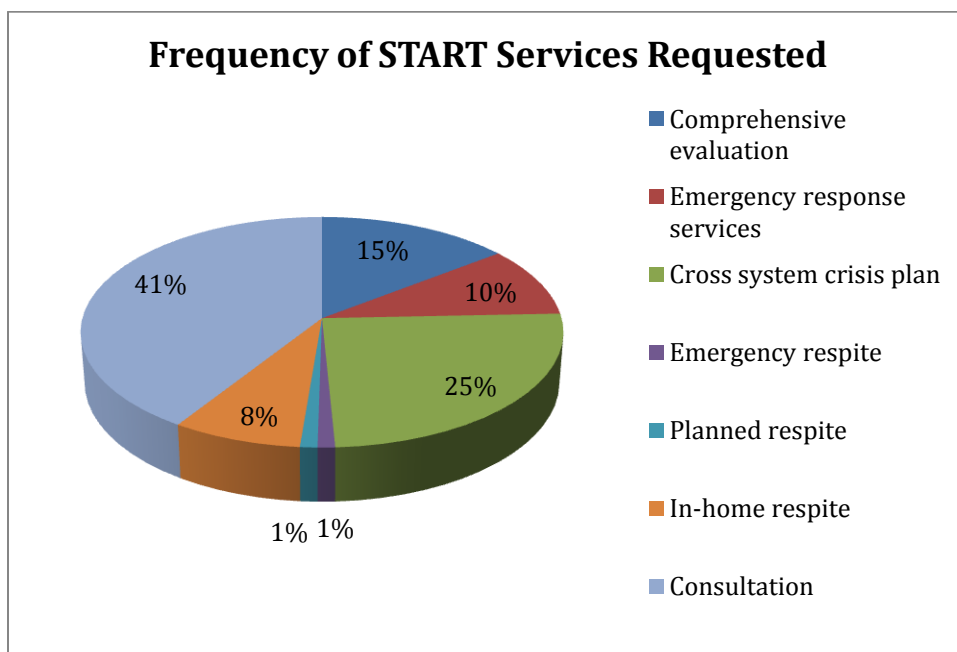
Of the 168 people who were hospitalized, it was reported that 33% of the admissions occurred in the last year with a total of 185 admissions, and over the past five years 39% of the population were hospitalized for a total of 368 admissions.

Seventy six people had a total of 185 admissions (range 1-15 individual admissions) in the last year for an average of approximately 2.5 admissions per individual. In addition, 92 individuals had 368 hospital admissions (range 1-30 individual admissions) over the last

five years for an average of approximately 4 admissions per individual reported. This data indicates that these people have high hospital recidivism rates. An important goal of the VA START program will be to address this issue and attempt to reduce the rate of repeated hospitalizations over time.

Total VA START Services Reported as of 12/31/12

Following is the aggregate frequency distribution of services provided by START teams in Virginia. No services were reported for Region 1 and limited services were reported for Region 2 as noted earlier. Respite services were limited to Region 3 only for center-based respite and in-home respite provided in Regions 3 and 5. Region 3 provided the majority of all respite services.

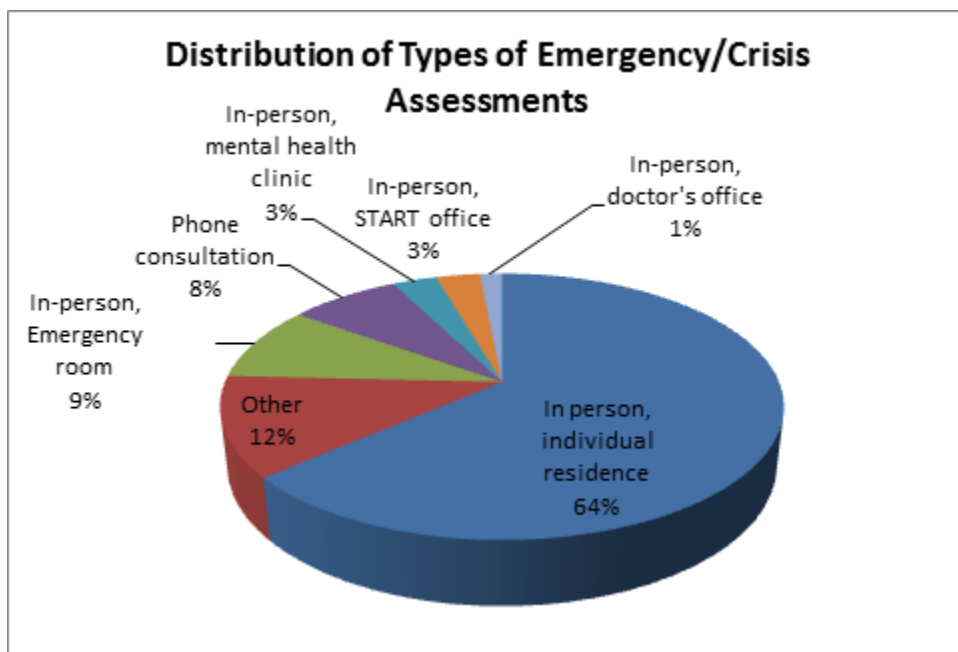


The majority of services were consultative supports (41%), followed by Cross Systems Crisis Prevention and Intervention Planning (25%), VA START Comprehensive Service Evaluations (15%), Emergency response supports (10%), In-home respite (8%), and Emergency and Planned Respite (1% each). It is anticipated that the respite services will significantly increase as the programs open across VA in the next quarter.

Emergency Contacts

START teams have worked to support 66 individuals across Virginia at the time of an emergency to date. 64% of evaluations/consultation occurred in person in people's homes. This is an excellent outcome and indicates that the START teams in Virginia take seriously their role as providing outreach where people live. It is expected that there will be an increased in emergency room consultations requested over time as the programs increase

their collaboration with emergency services throughout the state. We will also expect to see an increase of telephonic emergency supports provided once Cross Systems Crisis Prevention and Intervention Plans are in place. However, this should not increase too dramatically in the first year of operation given the fact that the VA START teams are in very early stages of implementation and need to assess most people in person at this point.

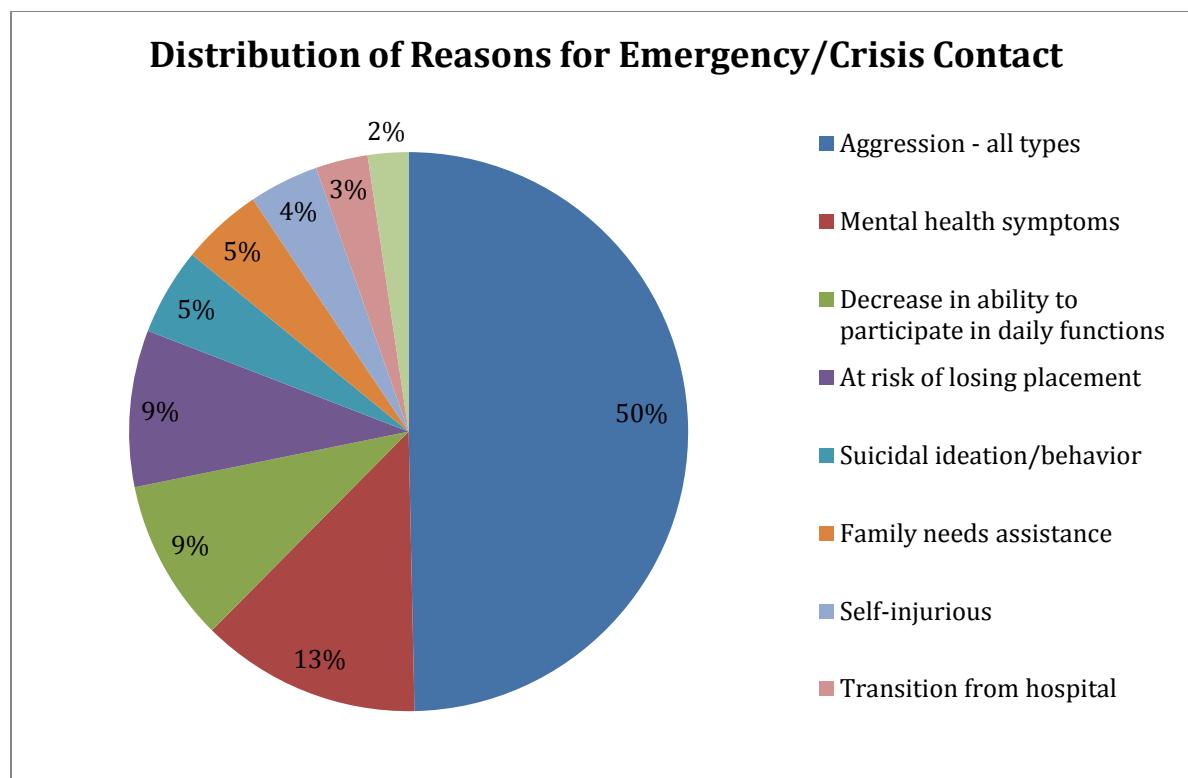


Reason for Referral

The following chart details the distribution of reasons for emergency/crisis contacts. The three top reasons for referral are aggression (50%); mental health symptoms (13%) and risk of losing placement (9%). As more individuals are included in the system, it is expected that the percentage of those referred for aggression will rise even further. Of interest, risk of losing placement is almost 10% of the group. This is a very promising finding. If the START team can work with people and their systems before they lose their placement, the risk of homelessness and/or institutionalization is lessened. We will explore the mental health symptom category further, as it is suspected that it may need to be better explained in future analyses.

Reasons for emergency referrals

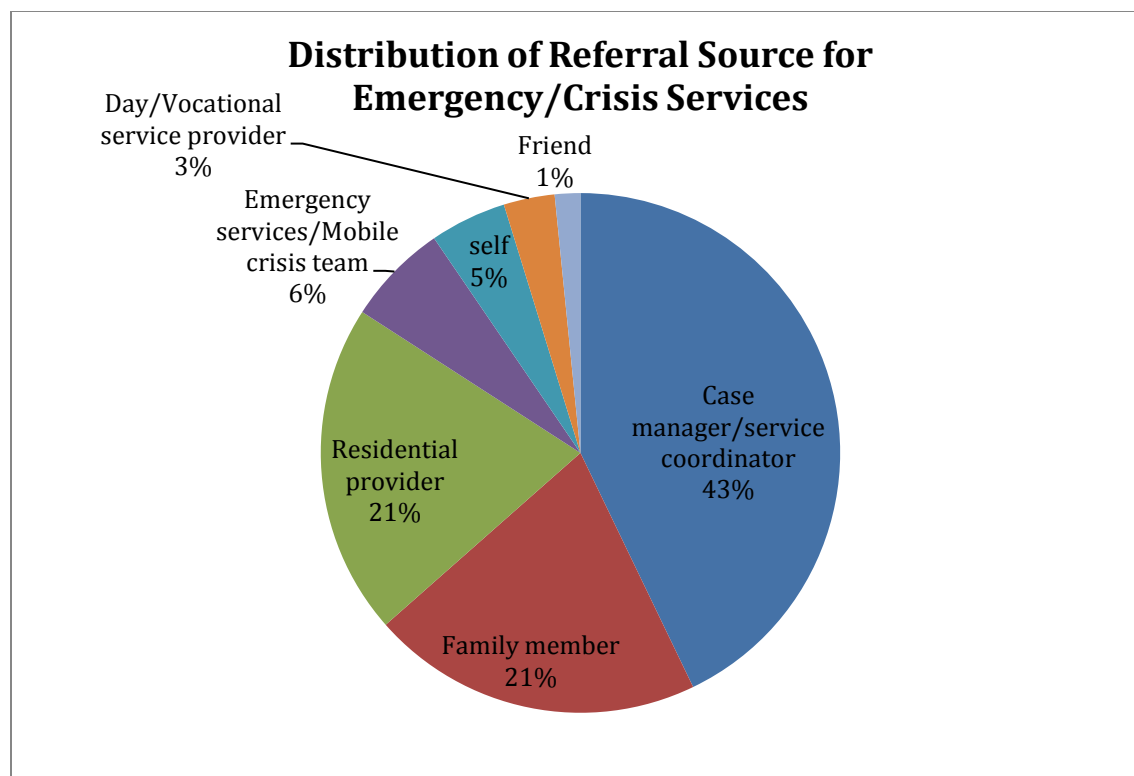
Following is a table outlining the reasons reported in the SIRS during a crisis contact with the START teams. It should be noted that this represents only 3 teams to date at various levels of after-hours availability since most teams transitioned into emergency service supports during this period. More robust data is expected in future reports.



Source of Referral

The following chart details the distribution of the sources of referral for emergency/crisis services.

The majority of crisis contacts came from service providers (case managers, residential providers, day programs). This is not surprising given the extent to which outreach to these providers to link with START teams has been significant, and these are the sources that know the individuals more closely. A very positive outcome is that 21% of referrals came directly from families. The access to families already in place will help to provide families with the support they need to prevent future crises. In addition 6% of contacts came from Emergency Services (ES) teams. This is expected to increase over time. The vignette that follows to describe outcomes provides an excellent example of the work being done to work with ES, case managers, and families to support individuals in the context of an emergency contact.



Emergency Contact Dispositions/Outcomes

The data collected in this category has some reporting difficulties, and will be reported in the next quarter to insure accuracy. The table below provides the total number of services provided immediately following a crisis contact for a total of 66 individuals. In completing the analysis, this reporter has requested improvements in reporting for this category because it is difficult to discern differences in categories and get a clear picture of outcomes. A vignette is provided below to provide an example of the VA START experience so far.

Emergency/Crisis Services

Number served 66

Final Outcome Disposition	Clients
In-home respite	42
Maintain current setting	23
Follow-up scheduled	16
Hospital diversion	11
State Psychiatric Hospital	6
Link to community resource	4
Referral out for services	4
Total number reported	106

Vignette 1:

This information about the case came to the our attention via an email from a START Coordinator on Christmas day:

"I wanted to let you both know that Director and the team were a blessing to a very special man who came to our attention last weekend. P came to our attention when his father was abruptly incarcerated for attempted murder. His father stabbed his girlfriend while he was intoxicated and when the police arrested him; they found P in the back of the van. P and his father had lived in this area for the last couple of years but P was not receiving any services. P was homeless and virtually unable to care for himself. He was non-verbal. Director went above and beyond to help P in to our Crisis Stabilization Unit with the understanding that START would provide support to him on the unit. Our team took turns spending time with P while Director was able to find out that this gentleman had family in Philadelphia. So, late on Christmas Eve, family came to get P and to take him back to Philadelphia. I wanted to let you know that we were all blessed by helping P and that for me, Christmas was even more special."

As reported later by the Director of the team, during the time P was at the CSU, the START Director was able to work with the HNN CSB CM assigned to the NN City Jail to get more information from P's father. On Monday December 24, 2012 the CM met with P's father. She was able to find out that P and his father had been in the area for approximately 2 years, he was not receiving any services, and his mother passed away 20 years ago. The client does receive SSI, Medicare, and Medicaid; however, his father was not willing to report where the cards were located.

During this time, the CM was able to assist P's father with searching the Internet for the phone numbers of family members in the Philadelphia area that may be able to assist with providing placement for the client. The CM contacted the client's sister and reported to her the situation and asked if she could assist. She was willing to come and pick up the client that day. She arrived at 9 p.m. on December 24, 2012 and took the client home with her.

The VA START Director has spoken with P's sister on several occasions and she reports he is doing well. She has indicated needing assistance with applying for benefits in Philadelphia as she works and she needs help with caring for P. Director was put in touch with a provider in Philadelphia who was able to provide information and that was relayed to P's sister.

START Director also contacted Adult Protective Services on Monday December 24, 2012 requesting assistance and was put in touch with Child Protective Services worker. She reported that they do not take custody of adults and that since P has "mental health needs" it is the responsibility of the CSB to provide housing and/or placement. On Wednesday December 26, 2012 an APS worker contacted the START Director to follow up and was informed of the sequence of events.

*P was not admitted to CSU, START provided space to work with him****

The ability of the system to work together with the support of the local START team to help this individual and prevent emergency placement in an institutional setting while working to find natural supports and services reflects much of the mission of the program. This resolution took many partners, and all linked with the support of the START team to help come to a very positive resolution.

Vignette 2

Charlene (not real name) is an 18 year-old, African American female, diagnosed with Moderate Intellectual Disability and Psychotic Disorder, NOS, Oppositional Defiant Disorder, Anxiety Disorder, and Selective Mutism. Charlene was referred to START due to reported difficulties of physical and verbal aggression in the home and school environment. Prior to the referral she had been hospitalized four times in the previous 6 months for “psychiatric decompensation.” START offered emergency support to assist in times of crisis to help prevent readmissions when possible.

START was contacted by Charlene’s case manager through our toll free crisis line. The case manager indicated that Charlene was having a “psychiatric meltdown,” while attending her day program. The on-call START Coordinator went to Charlene’s home. Upon entering the home, Charlene was observed to be calm and concerned about her Mother. Her mother was very upset, yelling, screaming, crying, overwhelmed and distraught. It appeared that her mother was the one in crisis at the fear of being homeless and unemployed.

Her mother was demanding for START to remove Charlene from the home and threatened that she may hurt her if Charlene was not removed from the home instantly. While collaborating with the CSB Case Manager, the START team assisted with diffusing the situation and contracting for safety without necessity of police involvement and hospitalization. The team worked to advocate for placement.

When the START coordinator followed-up, her mother was quite thankful for START’s involvement and both Charlene and her mother appeared to be in a better space. According to ongoing follow-up, Charlene has been removed from her mother’s home and currently resides in a group home. Since then, her medication regimen has been adjusted. She attends a different school and day support program. She participates in meals on wheels and has not been hospitalized in the past two months.

Vignette 3

A 26 year old Caucasian female diagnosed with moderate ID reported to the staff in her group home that she was “hearing voices” and was threatening suicide. Staff reported that they observed the client attempting to puncture her hand with a plastic fork that staff confiscated. START Region 2 was notified by emergency services of Arlington County that the group home was concerned about the client’s safety. The START team was called at 6:49 pm and responded by 8:06 pm. It was initially thought that a psychiatric admission might be required but the START team talked with the client until she was able to report that she wouldn’t harm herself.

She still complained of hearing voices but said she could wait until the morning when she would be able to see our Medical Director for an evaluation. With thorough interviewing and collection of third party information from staff and family it was learned that the client had been upset about not seeing her mother two weeks prior and staff reported that they had never observed the client complaining of hearing voices in the past. They observed changes in her behavior as she isolated from work and had continuous sleep disturbance for a week. While speaking with the client she reported feeling "sad" because she could not "make the voices stop." She exhibited behavior that appeared organized so a diagnosis of Depression with Psychotic Features was considered. In addition, the team considered the fact that the client may be trying to obtaining attention from her mother (who did not believe that the client was hearing voices).

START plans to help to arrange for a medical work-up to help determine if there is a medical origin to her distress. She has no prior history of mental health service use. A CSE (comprehensive service evaluation) is being conducted to get a clearer picture of her medical and service history and current needs, and we will also facilitate the development of a cross systems crisis prevention and intervention plan to assist before emergency services are required. She, her case manager, mother, and START Clinical Director attended her appointment with the START Medical Director and currently is on a low dose of medication. She will see the Medical Director for follow-up and a psychiatrist in the community is being sought for long term care. Our Medical Director will collaborate with her new MD as needed. She has reportedly gone back to work as she had missed two weeks because the "voices" were preventing her from attending work. We will continue to provide outreach and supports to the individual and her team until she has a clear diagnosis and treatment plan and has remained stable for an extended period of time.

There is a great deal to learn about the circumstances that resulted in this person's difficulties. It is the START team's role to ensure that the system responds effectively to situations and this often requires careful review of the system of support along with the person's presentation at the time of crisis.

Respite services

During the first two quarters of the fiscal year, there have been 196 in-home respite supports provided and 11 admissions for planned respite – all respite services were reported from Region 3.

Respite has been an important service in Region 3, and as of today (January 18, 2013) is now being provided in Region 1 as well. Data from Regional respite services after December 31st will be provided in the next reporting period. One important finding to date is the number of medical and medication related issues being identified during respite stays.

Respite vignettes

Vignette 1

Virginia Region 3 START team opened up their respite facility at the beginning of December for planned respite. One of our first guests was a male in his early thirties, diagnosed with Schizoaffective Disorder and Mild Intellectual Disability. His system reports he is at risk of losing his housing due to challenging behaviors that include constantly taking and eating toothpaste, taking items that do not belong to him and keeping them in his room, and agitation when asked about behavior or attempts as reported by his team.

Upon admission nursing staff quickly picked up on an issue potentially affecting his health and comfort. Nursing staff observed that his dentures appeared discolored with a foul odor, and to be slipping and or moving in his mouth. This information was collected and reviewed with his START coordinator and respite staff. Respite staff observed and documented through meals as well and noted the guest having difficulty while talking, eating, and drinking.

This guest agreed to let staff help him learn to clean his dentures that appeared to have not been cleaned for quite some time. His communication is limited but following staff help to develop dental cleaning skills he put the dentures in his mouth and smiled. He requested support each day in cleaning his dentures and during his stay no observation of his taking and eating toothpaste was observed. The START staff at the Respite Facility communicated this to his START Coordinator, who communicated to his team. They made arrangements for him to have time for his dentures to get cleaned daily, and also gave him the needed items to clean them himself. His START coordinator included this into his cross systems plan and reported that with each visit his dentures appeared much cleaner and he showed the coordinator the process he used to clean his dentures and smiled.

A second issue that became apparent during his visit was excessive fluid consumption. Although this was not noted in any of his medical history, it became clear that he was drinking very large amounts of fluid, over 150oz. the first day. His fluid intake was observed and documented to increase each day. The Respite staff followed up with his START Coordinator, who followed up with his primary team. They promptly got an appointment scheduled with his doctor for a full medical work up to rule out physiological causes for the excessive fluid consumption.

Both of these issues were discovered while a guest at START respite and had not been either noted or documented prior to his admission. A Cross Systems meeting has been held and another is scheduled to fully review all of these findings with his system.

Vignette 2

"I wanted to update you on a our guest that experienced a heart event while at respite. Staff responded and called 911. He was hospitalized and today they attempted to perform heart cath with introduction of a blood pressure medication. During this procedure they found

there was in fact previously undiagnosed heart damage. He was transferred to a large hospital in Roanoke for implementation on a pace maker tomorrow.

As I indicated he came in with a medical clearance and no documentation of any heart related dx. Our nurse staffed his case with the cardiologist at the hospital who stated he had clearly had previous heart events and his heart was in fact actually stopping and causing him to have episodes of passing out.

Suzanne (Respite Director) spoke with the family throughout the weekend and today. She made plans regarding returning his personal items. We planned to meet them or even take them to the family at the hospital. The family requested to come to respite to pick his items up. Suzanne said the family was in tears and said they could not express how thankful they were that this occurred while he was at respite and received immediate care.

Apparently the reason we could find no documentation regarding this issue is although this individual had been to his doctor for the past few months with events of pain and dizziness and even passing out, his PCP was adamant that he felt it was an attention seeking behavior and that he was fine with no medical issues. The family said they knew something was wrong and had observed the events and had noted a significant increase in his aggression during these events."

These stories indicate that while respite has been very helpful in order to improve the system of support, additional training to community primary care providers is needed. It also indicates that the START teams need to evaluate and revise their protocols with regard to medical exams at admission.

ABC (Aberrant Behavior Checklist)

The Aberrant Behavior Checklist is a validated instrument used to measure improvements in clients over time. All of the Regions will be conducting assessments and reporting results over time to assess the effectiveness of services and supports. The low number of ABCs is of concern given the requirement to conduct this assessment on all referrals.

There were 56 ABCs conducted with 39 (70%) at intake and 16 (28%) during a re-evaluation. There was also one ABC conducted during a respite admission.

Based on ongoing collaboration with Regional Teams and evaluation of the system as a whole, a list of issues to be addressed will be provided in each quarterly report, with progress noted in follow-up summaries.

Systems issues to be addressed:

1. Identification of who is in the state hospitals in need of help from START. What is the process? There should be written policies and procedures shared with the START teams.
2. Engagement of START in developing transition and crisis plans for those leaving the training centers. There should be written policies and procedures shared with the START teams.
3. Expediting the assignment of case management to those who are eligible for ID or DD services when they are referred to START in an emergency situation. Is there a policy about this? Again, a written policy and procedures should be shared with the teams.
4. Bridge payments for residential providers for up to 30 days should be considered so that they can hold a bed open, and work actively with START team, respite and/or inpatient unit along with START to successfully return and remain at home. Providers are discharging clients not because they want to but because they cannot get funding to provide support unless the person is at their residence. This has been mentioned several times in discussions. START partners will not be effective unless they are able to work with START to learn how to more effectively serve clients in the community. The payment issue is an obstacle for some residential providers and needs to be addressed.
5. There continues to be the need for written policies with regard to the ES teams and their partnership with START teams. While some progress has been made, ES teams need to be trained to better assess the mental health needs of persons with IDD. Training is available, and we await a plan to make this easily available to ES workers.
6. It has become very apparent that the need for better medical screening is needed prior to admission to START respite programs. A request for all medical personnel to work together with Bob Villa to provide guidelines was sent. Please respond to this important request.

Service findings to date:

1. Trends from the current SIRS analysis indicates that diagnosis and treatment planning is either being unreported, needs improvement or both. Despite the high rate of hospital admissions, there is a lack of mental health diagnoses. In addition, despite the high degree of medical and medication problems found at respite so far, there is a low rate of medical diagnosis and treatment planning in the population to date. The START teams will need to focus on these findings to link with community partners and provide assistance and improve outcomes whenever possible.

2. Please provide ABC and MEDS assessment on all clients as indicated.
3. There is little information from Regions 1 and 2 but information provided by Regions 3-5 have shown that even in the earliest stages of development the program has had a significant positive effect.
4. In early stages of crisis contact, many emergency service providers have collaborated well with the START programs. The support to do this has been very helpful and should continue.

As of the date of this report (January, 2013) , all START teams in Virginia are operating, and we expect more robust data to evaluate in future reports.

The next report will include more specific data with regard to services provided by the teams and more in-depth analysis of outcomes as the SIRS will have more data and the teams will have more to report, since services will expand. We will also provide analysis between regions. Regions should be reporting their specific data to their advisory councils as well.

Thank you for the tremendous effort throughout the state to improve services to individuals with IDD and behavioral health needs. We have included only a few of the personal stories to date. The VA START program is making a difference today and will have an even greater impact as they are fully operational in the future.

This program is in its earliest stages of development. It has been a pleasure to work with all five Regions as they strive to develop and implement excellent START services.

One final note: the START program in Virginia is not fully implemented in most locations, and this aggregate (combined data) report may result in some Regional Advisory Council's concern that their region does not yet offer most or many of the services outlined in this report. It is important that Regional START team Directors be very clear about timelines for full implementation with all local stakeholders, including families so that they will not be discouraged by delays in implementation. In the meantime, all teams are equipped to make a difference, and it is important that each region be a responsive and creative with existing resources as possible.

It is our expectation that the next quarter will provide more individual region information so that we can take a closer look at where things are at locally.

Following is an outline of National Center training and SIRS update. In addition, we continue to provide ongoing consultation and technical support along with regional visits.

UNH/IOD Services and Supports

Ongoing technical assistance including monthly conference calls, study groups and regional visits continued in this quarter. Following is a Table to outline training provided.

UNH/START Trainings

Date	Time (EST)	Training
Ongoing	On Demand	<ul style="list-style-type: none"> • Overview of START • MH Aspects of IDD • Role of START Coordinator • Evidence-Based Treatment for IDD & Medical Director Networking Meeting • Psychopharmacology & IDD • Cross Systems Crisis Prevention & Intervention • Autism Spectrum Disorders • Emergency Crisis Assessments of Individuals with IDD and Behavioral Health Needs • Diagnosis & CETs • Schizophrenia, Psychotic Disorders & IDD • Mood Disorders: Depression & Bipolar Disorder • Anxiety Disorders & IDD • Positive Behavior Supports
November 16, 2012	On Demand	Special Presentation: How to Use Eco maps as Part of Systemic Analysis
November 30, 2012	10 a.m. to 12 p.m.	Special CET with Dr. Angela Hassiotis
Ongoing	Ongoing	Access to the 2011-2012 START Online Training Series on MH & IDD <ul style="list-style-type: none"> • Major Depression & Obsessive Compulsive Disorders in Persons with Down Syndrome • When in Doubt, Rule it Out (Medical Issues & IDD) • Positive Behavior Support for People with IDD & MH Needs • Psychopharmacology & IDD • Understanding Dialectical Behavior Therapy for Persons with MH & IDD • Trauma & Intellectual Disability
Ongoing	Ongoing	Access to 2012-2013 START Online Training Series on MH & IDD: <ul style="list-style-type: none"> • Physicians & Clinicians Series, Part 1: Introduction to ID & Developmental Disorders • Physicians & Clinicians Series, Part 2: Mood & Anxiety Disorders in Persons with IDD • Physicians & Clinicians Series, Part 3: Psychoses, Delirium & Other Neuropsychiatric Disorders • Physicians & Clinicians Series, Part 4: Autism & the Neuropsychiatry of Epilepsy, Sleep Disorders & Movement Disorders

UNH/ Data Collection and Reporting

The SIRS has continued to refine the VA START data collection including changes in the privilege structure (assuring integrity of the data), and discussion leading to consensus on the data element definitions in the Data Dictionary. The focus going forward will be to continue refinements with a focus on report formats and training on how to utilize the data export function for regional analysis.

Respectfully submitted,

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